



RECOMMENDATION FOR DRIVER REEXAMINATION

This recommendation must provide specific information regarding medical/visual conditions and/or driving abilities of the person in question and must be made in the interest of public safety only. Age is not a consideration. Based on the information provided we will investigate and take action as necessary. Insufficient information may result in no action being taken. Due to confidentiality, we are unable to divulge the outcome of this recommendation to you.

Information on this form shall be provided to the driver or his/her attorney upon request.

Based upon my personal observation and knowledge, I recommend the following driver's qualifications be reviewed.

NAME OF DRIVER (First, Middle, Last)			BIRTH DATE
RESIDENCE ADDRESS			TELEPHONE NUMBER
CITY	STATE	ZIP CODE	DRIVER LICENSE NUMBER
DETAILED STATEMENT 			
NAME OF PERSON REPORTING			
ADDRESS			TELEPHONE NUMBER
CITY	STATE	ZIP CODE	RELATIONSHIP TO DRIVER

I certify (declare) under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

X

SIGNATURE

DATE

LAW ENFORCEMENT ONLY —Complete this section IN ADDITION TO top portion	
LAW ENFORCEMENT AGENCY	BADGE NUMBER
THIS INFORMATION IS BASED ON <input type="checkbox"/> Citation/Traffic Violation Stop <input type="checkbox"/> Accident Investigation with Serious Injury <input type="checkbox"/> Accident Investigation with Fatality <input type="checkbox"/> Court Appearance <input type="checkbox"/> Other _____	
PLEASE EXPLAIN 	

Attach any additional information or documents. Additional witnesses must complete separate forms.

Return this form to: Department of Licensing, Driver Services, PO Box 9030, Olympia, WA 98507-9030

The Department of Licensing has a policy of providing equal access to its services.

If you need special accommodation, please call (360) 902-3900 or TTY (360) 664-0116.

DLE-520-005 RECOMMEND REEXAM (R/3/02)OR/W